RAPID REFERRAL · PRIMARY CARE

Suspected Cancer: Recognise & Refer

A fast, memorable bedside guide to the symptoms that should make you act — fully rebuilt on **NICE NG12**, last updated **15 April 2026**.

Updated to NICE NG12 (Apr 2026) | FIT · CA125 · PSA thresholds | For GP trainees & IMGs

◆ THE ONE IDEA TO HOLD ONTO

Most people you refer will **not** have cancer — and that is exactly the point. Your job is not to diagnose cancer in primary care; it is to **spot the patient who deserves a faster look** and start the right pathway quickly. When in doubt, and clinical concern persists, **refer anyway** — a normal test does not cancel a worried clinician.

First, learn the referral language

SPEAK THE SYSTEM

Every recommendation in this guide uses one of these terms. Learn them once and the rest of the document reads itself.

2-WEEK PATHWAY

Suspected cancer pathway referral

The patient must have cancer **diagnosed or excluded within 28 days** of your urgent referral. This is the NHS **Faster Diagnosis Standard** — the modern name for the old "two-week wait".

Renamed/redefined Oct 2023

48 HOURS

Very urgent

Seen or investigated **within 48 hours**. Reserved largely for **children and young people** and for results that cannot wait.

e.g. suspected childhood leukaemia, sarcoma

DIRECT ACCESS

Direct-access test

You order the test (CXR, USS, CT, bloods) and **you stay responsible for acting on the result**. "Urgent" here means within 2 weeks.

Keeps the diagnostic clock with you

ROUTINE

Non-urgent referral

Standard timescale — used when cancer is possible but unlikely (e.g. most basal cell carcinomas).

NSS PATHWAY

Non-specific symptoms pathway

For people whose symptoms point to cancer but fit **no single tumour pathway** — weight loss, fatigue, or a GP "gut feeling".

AGES

Who is a "child"?

Child = 0–15 · **Young person** = 16–24 · **Children & young people** = 0–24. Age changes the pathway, so check it first.

▸ HOW TO READ EVERY CARD IN THIS GUIDE

① RECOGNISE	→	② ACT	→	③ REFER / SAFETY-NET
The symptom pattern that should make you stop and think.		The test to order — or the referral to make — and how fast.		Where it goes, and what to tell the patient before they leave.

REFER / OFFER = NICE says do this (strong). **CONSIDER** = use your clinical judgement. The colour of the pill tells you the **speed**.

What's changed since the old guidance

If you trained on the 2015/2022 version (or the old Macmillan booklet), these are the seven updates that genuinely change what you do on a Monday morning. **Everything else is broadly the same.**

▲ THE SEVEN UPDATES THAT MATTER

Topic	What it used to say	What NICE says now
Bowel (lower GI) The biggest change	Refer on symptom clusters; FIT only for a narrow group.	**FIT is now central.** Offer quantitative FIT for the listed symptom groups and **refer if FIT ≥10 µg Hb/g**. Do **not** delay referral if strong clinical concern (e.g. a mass) persists. *2023*
Ovary	CA125 for all; ultrasound if CA125 ≥35 IU/ml.	**Under-40s:** don't use CA125 alone — go to ultrasound. **40+:** CA125 with **age-banded thresholds** (some **below 35**). *2026*
Endometrium	Refer 55+ with postmenopausal bleeding (PMB).	PMB must be **"not attributable to HRT"**. Bleeding **on** HRT is handled separately — follow **British Menopause Society** guidance. *2026*
Myeloma	Protein electrophoresis + Bence-Jones urine.	Serum protein electrophoresis **plus serum free light chains**. Bence-Jones urine **only if** serum free light chains unavailable. *2025 · incorrect test removed Jan 2026*
Oesophagus & stomach	"Urgent direct-access endoscopy within 2 weeks".	Now a **suspected cancer pathway referral** for dysphagia, or 55+ with weight loss plus an upper-GI symptom. *2025*
Weight loss (60+)	No specific non-site rule.	New: 60+ with **unexplained weight loss >5% over 6 months** → assess for clues, then urgent investigation, suspected cancer pathway, or non-specific symptoms pathway. *2026*
The words	"Two-week wait / urgent referral".	**Suspected cancer pathway referral** — cancer ruled in or out within **28 days** (Faster Diagnosis Standard). *Oct 2023*

◎ A MEMORY HOOK FOR THE BOWEL CHANGE

Think of FIT as a **traffic light on the referral door**. A result of **≥10 turns the light green** for a suspected cancer pathway referral. But the light has an **override switch**: if you are clinically worried (a mass, ongoing unexplained symptoms), you **refer regardless of the number**. The test guides you; it never overrules you.

Map of this guide

13 SYSTEMS

1 · Lung & pleura
Lung · mesothelioma

2 · Upper GI
Oesophagus · stomach · pancreas · liver · gallbladder

3 · Lower GI
Colorectal (FIT) · anal

4 · Breast

5 · Gynaecological
Ovary · endometrium · cervix · vulva · vagina

6 · Urological
Prostate · bladder · renal · testis · penis

7 · Skin
Melanoma · SCC · BCC

8 · Head & neck
Larynx · oral · thyroid

9 · Brain & CNS

10 · Haematological
Leukaemia · myeloma · lymphoma

11 · Sarcoma
Bone · soft tissue

12 · Childhood cancers

13 · Non-site-specific symptoms & safety netting — weight loss · appetite loss · DVT · what to tell the patient

1 Lung & pleural cancers

LUNG · MESOTHELIOMA

▲ THE CHEST X-RAY TRAP

A normal chest X-ray does NOT exclude lung cancer. Around 1 in 4 X-rays taken in primary care within a year of a lung cancer diagnosis were reported as normal. If symptoms persist after a clear film, **refer or re-investigate** — do not be falsely reassured.

Lung cancer

2-WEEK PATHWAY · CXR ≤2 WKS

REFER	**Suspected cancer pathway referral** if either: chest X-ray suggests lung cancer; **or** aged **40+** with **unexplained haemoptysis**.
OFFER CXR	**Urgent direct-access chest X-ray** (≤2 weeks) if aged **40+** with **two or more** of the symptoms below — or **one or more** if they have **ever smoked**: cough · fatigue · shortness of breath · chest pain · weight loss · appetite loss
CONSIDER CXR	Urgent chest X-ray if aged **40+** with any of: persistent/recurrent chest infection · finger clubbing · supraclavicular or persistent cervical lymphadenopathy · chest signs of lung cancer · **thrombocytosis**.

Mesothelioma

2-WEEK PATHWAY · CXR ≤2 WKS

REFER	**Suspected cancer pathway referral** if chest X-ray suggests mesothelioma.
OFFER CXR	Urgent chest X-ray if aged **40+** and: **two or more** of the symptoms above; **or one or more** if they have ever smoked; **or one or more** with **asbestos exposure**.
CONSIDER CXR	Urgent chest X-ray if aged 40+ with **finger clubbing** or chest signs of pleural disease.

◆ BOTTOM LINE

Haemoptysis in the over-40s, or any X-ray shadow, goes straight onto the cancer pathway. Ever-smoked lowers the threshold for ordering the film from two symptoms to one. Asbestos exposure does the same for mesothelioma.

▸ MEMORY HOOK — COUNT THE SYMPTOMS

For the chest X-ray, think **"two if you never smoked, one if you ever did."** Two qualifying symptoms in any over-40, or just one if they have ever smoked (or been exposed to asbestos), is enough to order the urgent film.

2 Upper gastrointestinal cancers

OESOPHAGUS · STOMACH · PANCREAS · LIVER

▲ WHAT CHANGED

Dysphagia, and 55+ with weight loss plus an upper-GI symptom, now trigger a **suspected cancer pathway referral** — not the old "urgent direct-access endoscopy" wording. The endoscopy still happens; the **route is now the cancer pathway**.

NICE NG12, amended 2025

Oesophageal & stomach cancer

2-WEEK PATHWAY

REFER	**Suspected cancer pathway referral** if: **dysphagia at any age**; **or** aged **55+** with **weight loss** plus **upper abdominal pain, reflux or dyspepsia**.
CONSIDER	Suspected cancer pathway referral for an **upper abdominal mass** consistent with stomach cancer.
THEN OGD	**Non-urgent direct-access endoscopy** if: haematemesis; **or** 55+ with treatment-resistant dyspepsia, or upper abdominal pain + low haemoglobin, or raised platelets / nausea-vomiting combined with weight loss, reflux, dyspepsia or upper abdominal pain.

Pancreatic cancer

2-WEEK PATHWAY · CT ≤2 WKS

REFER	**Suspected cancer pathway referral** if aged **40+** with **jaundice**.
CONSIDER CT	**Urgent direct-access CT** (ultrasound if CT unavailable) if aged **60+** with **weight loss** plus any of: diarrhoea · back pain · abdominal pain · nausea · vomiting · constipation · **new-onset diabetes**.
WHY CT	CT is preferred where available — it is more sensitive than ultrasound for small tumours and also stages the disease.

Gall bladder

USS ≤2 WKS

CONSIDER	Urgent direct-access ultrasound for an upper abdominal mass consistent with an **enlarged gall bladder**.

Liver

USS ≤2 WKS

CONSIDER	Urgent direct-access ultrasound for an upper abdominal mass consistent with an **enlarged liver**.

◆ BOTTOM LINE

Dysphagia at any age, and jaundice over 40, are the headline alarms. Add **weight loss + an upper-GI symptom in the over-55s** and you are on the cancer pathway. An upper abdominal mass earns urgent imaging — ultrasound for liver and gall bladder, CT for pancreas.

3 Lower gastrointestinal cancers

COLORECTAL (FIT) · ANAL

▲ THE BIG ONE: FIT NOW LEADS THE PATHWAY

Quantitative **faecal immunochemical testing (FIT)** now guides nearly every colorectal referral. Offer FIT first, then let the number — with your clinical judgement — decide. *NICE NG12 / HTG690, 2023*

Colorectal cancer

OFFER FIT FIRST · REFER IF ≥10

OFFER FIT — **Offer quantitative FIT** to guide referral in adults with any of:

- an **abdominal mass**
- a **change in bowel habit**
- **iron-deficiency anaemia**
- 40+ with weight loss **and** abdominal pain
- under 50 with rectal bleeding **and** abdominal pain or weight loss
- 50+ with rectal bleeding, abdominal pain or weight loss
- 60+ with **anaemia even without iron deficiency**

Offer FIT **even if a recent screening FIT was negative.**

REFER — **Suspected cancer pathway referral if FIT ≥ 10 µg haemoglobin / g faeces.**

NO FIT NEEDED — Do **not** wait for FIT before considering referral for a **rectal mass**, an **unexplained anal mass**, or **anal ulceration**.

The colorectal decision in one picture:

1 Symptoms from the list above
Change in bowel habit, IDA, abdominal mass/pain, rectal bleeding, weight loss, or anaemia in the over-60s.

2 Offer FIT — and support the patient to return the sample
A rectal/anal mass or anal ulceration skips this step and is considered for referral directly.

3

FIT ≥ 10 µg/g
→ **Suspected cancer pathway referral.**

FIT < 10 µg/g, or no sample
→ **Safety-net** and review. **Do not delay referral** if clinical concern is strong (e.g. a mass).

Anal cancer

2-WEEK PATHWAY

CONSIDER — Suspected cancer pathway referral for an **unexplained anal mass** or **unexplained anal ulceration**.

◆ BOTTOM LINE

FIT ≥ 10 = refer. But FIT is a guide, not a gatekeeper — a convincing clinical picture (especially a mass) is referred whatever the number says, and a negative screening FIT never blocks a symptomatic test.

4 Breast cancer

◎ Breast cancer

2-WEEK PATHWAY

REFER — **Suspected cancer pathway referral** if: aged **30+** with an **unexplained breast lump** (with or without pain); **or** aged **50+** with any of these in **one nipple only** — discharge, retraction, or other change of concern.

CONSIDER — Suspected cancer pathway referral for **skin changes** suggesting breast cancer, or aged **30+** with an **unexplained axillary lump**.

UNDER 30 — **Non-urgent referral** for an unexplained breast lump (with or without pain).

▸ MEMORY HOOK — THE 30 / 50 RULE
Lumps from 30, nipples from 50. A new breast lump earns the cancer pathway from age 30; one-sided nipple change earns it from 50. Younger than 30 with a lump → still seen, just routinely.

5 Gynaecological cancers

OVARY · ENDOMETRIUM · CERVIX · VULVA · VAGINA

♀ Ovarian cancer

2-WEEK PATHWAY | AGE-BASED TESTING

REFER — **Suspected cancer pathway referral** to a gynae-oncology service if examination finds **ascites** and/or a **pelvic or abdominal mass** not obviously fibroids.

TEST IF... — Symptoms **persistent or frequent** (especially >12×/month), particularly in the over-50s: **bloating** · early satiety / appetite loss · pelvic or abdominal pain · urinary urgency or frequency. Also test if 50+ with new IBS-like symptoms (**IBS rarely starts at this age**), or with unexplained weight loss, fatigue or change in bowel habit.

▲ WHAT CHANGED — OVARIAN TESTING IS NOW AGE-LED
Under 40: CA125 is unreliable here — **do not use it alone**; consider an **urgent ultrasound** of abdomen and pelvis. **40 and over:** measure CA125, then arrange ultrasound using **age-specific thresholds** — several of which are now **lower than the old 35**. *NICE NG12, 2026*

Age & serum CA125 → arrange urgent ultrasound

Age (years)	CA125 threshold
Under 40	**Ultrasound — don't use CA125 alone**
40–49	**≥ 35 IU/ml**
50–59	**≥ 31 IU/ml**
60–69	**≥ 24 IU/ml**
70–79	**≥ 25 IU/ml**
80+	**≥ 31 IU/ml**

NICE NG12 Table 1 (2026)

Then...

Ultrasound suggests ovarian cancer
→ **Suspected cancer pathway referral** to gynae-oncology.

CA125 below threshold, or normal scan
Look for another cause and investigate it. If none found, **safety-net**: return if symptoms become more frequent or persistent.

◆ REMEMBER
The older you are, the **lower** the CA125 that should worry you — the threshold drops into the 20s in the 60s and 70s.

Endometrial cancer

2-WEEK PATHWAY

REFER **Suspected cancer pathway referral** if aged **55+** with **unexplained postmenopausal bleeding that cannot be attributed to HRT**.

CONSIDER Suspected cancer pathway referral if aged **under 55** with unexplained postmenopausal bleeding not attributable to HRT.

CONSIDER USS Urgent direct-access ultrasound if aged **55+** with: unexplained **vaginal discharge** (first presentation, or with thrombocytosis, or with haematuria); **or visible haematuria** plus low haemoglobin, thrombocytosis or high blood glucose.

▲ WHAT CHANGED — BLEEDING ON HRT IS NOW A SEPARATE QUESTION

Two of these words now do the heavy lifting: **"not attributable to HRT."** If the bleeding is plausibly HRT-related (settling-in, or after a dose/preparation change), it is **unscheduled bleeding on HRT** — a different problem. NICE notes **limited evidence** here and directs you to **British Menopause Society** guidance on unscheduled bleeding on HRT. *NICE NG12, 2026*

▸ A CLEAN WAY TO THINK ABOUT POSTMENOPAUSAL BLEEDING

Ask one question first: **"Could this bleeding be the HRT?"**

- **No / not on HRT** → unexplained PMB → **cancer pathway** (refer 55+, consider under 55).
- **Yes, plausibly the HRT** → unscheduled bleeding on HRT → **assess per BMS guidance**, not automatically the cancer pathway.

Cervical

2-WK

CONSIDER Suspected cancer pathway referral if the **cervix looks like cancer** on examination.

No smear needed first — and a previous normal smear must **never** delay referral.

Vulval

2-WK

CONSIDER Pathway referral for an unexplained vulval **lump, ulceration or bleeding**.

Vaginal

2-WK

CONSIDER Pathway referral for an unexplained **palpable mass** in or at the entrance to the vagina.

6 Urological cancers

PROSTATE · BLADDER · RENAL · TESTIS · PENIS

Prostate cancer

2-WEEK PATHWAY

REFER **Suspected cancer pathway referral** if the prostate **feels malignant on digital rectal examination**.

PSA + DRE Consider PSA and DRE if: any **lower urinary tract symptoms** (nocturia, frequency, hesitancy, urgency, retention); **or** erectile dysfunction; **or** visible haematuria.

CONSIDER Refer on the cancer pathway if PSA is **above the age threshold** (table below). Factor in the person's preferences and comorbidities.

Age (years)	PSA threshold (micrograms/litre)	Age (years)	PSA threshold (micrograms/litre)
Below 40	Use clinical judgement	60–69	**More than 4.5**
40–49	More than 2.5	70–79	**More than 6.5**
50–59	More than 3.5	Above 79	**Use clinical judgement**

NICE NG12 Table 2 — age-specific PSA thresholds for people with possible symptoms of prostate cancer (2021)

Bladder

2-WK

REFER **45+** with unexplained **visible haematuria** (no UTI, or recurring after UTI treatment); **or 60+** with unexplained **non-visible haematuria** plus dysuria or raised white cells.

CONSIDER Non-urgent referral if 60+ with recurrent/persistent unexplained UTI.

Renal

2-WK

REFER **45+** with unexplained **visible haematuria** without UTI, or visible haematuria that persists/recurs after UTI treatment.

Testicular

2-WK USS

CONSIDER Pathway referral for **non-painful enlargement** or change in **shape/texture** of the testis.

OR USS Urgent direct-access ultrasound for unexplained or persistent testicular symptoms.

Penile

2-WK

CONSIDER Pathway referral for a **penile mass or ulcer** (once STI excluded/treated), or unexplained persistent foreskin/glans symptoms.

▸ HAEMATURIA AT A GLANCE — WHO CROSSES THE LINE?

Finding	Who	Action
Visible haematuria, unexplained	Aged **45+** — no UTI, **or** persisting/recurring after UTI treatment	**Refer** — suspected cancer pathway (covers **both bladder and renal**)
Non-visible haematuria, unexplained	Aged **60+** with **dysuria** or a **raised white cell count**	**Refer** — suspected cancer pathway (bladder)
Recurrent / persistent **unexplained UTI**	Aged **60+**	**Consider** non-urgent referral (bladder)

Synthesised from NICE NG12 bladder & renal cancer recommendations (1.6.4–1.6.6)

◆ BOTTOM LINE — THE HAEMATURIA RULE

Visible haematuria from 45 = bladder + renal pathway. Non-visible haematuria needs more (60+, plus dysuria or raised white cells) to cross the line. A malignant-feeling prostate goes straight to referral — don't wait for the PSA.

7 Skin cancers

MELANOMA · SCC · BCC

Malignant melanoma

2-WEEK PATHWAY

REFER **Suspected cancer pathway referral** if a suspicious pigmented lesion scores **3 or more** on the weighted 7-point checklist, **or** dermoscopy suggests melanoma.

CONSIDER Pathway referral for any pigmented **or non-pigmented** lesion suggesting **nodular melanoma** (these can be amelanotic — don't be reassured by lack of pigment).

Major features — 2 points each

- Change in **size**
- Irregular **shape**
- Irregular **colour**

Minor features — 1 point each

- Diameter **≥7 mm**
- Inflammation
- Oozing
- Change in sensation

Weighted 7-point checklist — score ≥3 prompts a suspected cancer pathway referral. NICE NG12.

Squamous cell carcinoma

2-WK

CONSIDER Pathway referral for a lesion that **raises suspicion of SCC** — typically a scaly, crusted or ulcerated growing lesion.

Lower your threshold in the immunosuppressed and transplant recipients.

Basal cell carcinoma

ROUTINE

CONSIDER **Non-urgent** referral for a lesion suspicious of BCC — ulcer with a **raised rolled edge**, fine surface vessels, or a **pearly/waxy nodule**.

URGENT ONLY IF delay would significantly impact (e.g. critical site or size). Follow NICE CSG8 on who should excise.

◆ BOTTOM LINE

Melanoma and SCC ride the cancer pathway; most BCCs go routinely. Score the pigmented lesion (≥3 refers), respect the amelanotic nodular melanoma, and excise BCC only per NICE CSG8.

8 Head & neck cancers

LARYNX · ORAL · THYROID

Laryngeal

2-WK

CONSIDER **45+** with persistent unexplained **hoarseness** or an unexplained **neck lump**.

Oral

2-WK

CONSIDER Unexplained oral **ulceration >3 weeks**, or a persistent unexplained neck lump.

DENTIST Urgent dental assessment for a lip/oral lump or a **red / red-and-white patch** (erythroplakia).

Thyroid

2-WK

CONSIDER Pathway referral for an **unexplained thyroid lump**.

9 Brain & central nervous system

Adults — MRI ≤2 WKS

CONSIDER **Urgent direct-access MRI brain** (CT if MRI contraindicated) for **progressive, sub-acute loss of central neurological function**.

Children & young people — 48 HOURS

CONSIDER **Very urgent referral (48 h)** for newly abnormal **cerebellar or other central neurological function**.

▸ PRACTICE POINT
A normal scan does not always reassure — some pathology is invisible to MRI, and incidental findings are common. Keep following up the patient, not just the picture.

10 Haematological cancers — LEUKAEMIA · MYELOMA · LYMPHOMA

Leukaemia — FBC ≤48 H

CHILDREN **Immediate** specialist assessment for any child or young person with unexplained **petechiae** or **hepatosplenomegaly**.

OFFER FBC **Very urgent full blood count (48 h)** in children/young people with any of: pallor · persistent fatigue · unexplained fever · persistent infection · generalised lymphadenopathy · persistent/unexplained bone pain · bruising · bleeding.

ADULTS Consider a **very urgent FBC (48 h)** for the same picture in adults — add petechiae and hepatosplenomegaly to the list.

Myeloma — BLOOD PANEL · REFER IF POSITIVE

OFFER BLOODS In people aged **60+** with persistent bone pain (especially **back pain**) or an **unexplained fracture**, offer a full blood count **and** blood tests for:

- **calcium**
- plasma viscosity **or** ESR
- paraprotein — **serum protein electrophoresis**
- **serum free light chains**

If serum free light chain testing is **not available**, use a **Bence-Jones (urine)** test instead.

REFER **Suspected cancer pathway referral** if these results suggest myeloma.

▲ WHAT CHANGED — THE MYELOMA BLOOD PANEL
The old reflex was "**protein electrophoresis + Bence-Jones urine**". NICE now leads with **serum protein electrophoresis plus serum free light chains**, and keeps Bence-Jones urine only as a **fallback when serum free light chains aren't available**. An incorrect blood-test recommendation was also removed in January 2026. *NICE NG12, amended 2025–2026*

Lymphoma (Hodgkin & non-Hodgkin) — ADULTS 2-WK · CHILDREN 48 H

ADULTS **Suspected cancer pathway referral** for unexplained **lymphadenopathy** or **splenomegaly**.

CHILDREN **Very urgent referral (48 h)** for unexplained lymphadenopathy or splenomegaly.

WEIGH UP associated **B-symptoms**: fever · night sweats · shortness of breath · pruritus · weight loss. In Hodgkin, also **alcohol-induced lymph-node pain**.

◆ BOTTOM LINE
Children with petechiae or hepatosplenomegaly cannot wait — same-day. For myeloma, think **"old back that won't settle"** and send the full panel including **serum free light chains**. Persistent unexplained lymphadenopathy is lymphoma until proven otherwise.

11 Sarcomas

BONE · SOFT TISSUE

One rule runs through all sarcoma: adults take the 2-week pathway, children and young people take the 48-hour very-urgent route. The investigation is the same — **X-ray for bone, ultrasound for soft tissue**.

Bone sarcoma

CHILD 48 H · ADULT 2-WK

CHILD X-RAY — **Very urgent direct-access X-ray** for unexplained bone swelling or pain.

IF X-RAY + — Child/young person → **very urgent referral (48 h)**. Adult → **2-week pathway**.

Soft tissue sarcoma

CHILD 48 H · USS

USS — Ultrasound for an **unexplained lump that is increasing in size** — urgent in adults, **very urgent (48 h)** in children.

IF USS + — or if findings are uncertain and concern persists → refer (adults 2-wk; children 48 h).

▸ MEMORY HOOK

"A growing lump in a child is a 48-hour problem." The faster clock for children runs through sarcoma, leukaemia, lymphoma, brain and the childhood cancers below.

12 Childhood cancers

NEUROBLASTOMA · RETINOBLASTOMA · WILMS'

Neuroblastoma

48 H

CONSIDER — **Very urgent referral (48 h)** for a palpable **abdominal mass** or unexplained enlarged abdominal organ.

Retinoblastoma

PATHWAY

CONSIDER — Ophthalmology pathway referral for an **absent red reflex**. (New-onset squint with absent red reflex → see NICE NG127.)

Wilms' tumour

48 H

CONSIDER — **Very urgent (48 h)** for a palpable abdominal mass, enlarged abdominal organ, or **unexplained visible haematuria**.

▲ LISTEN TO THE PARENTS

Take the **insight of parents and carers seriously**. Consider referral when a parent has **persistent concern or anxiety** about a child's symptoms — even when the most likely cause is benign. Persistent parental worry is itself a red flag.

13 Non-site-specific symptoms

WHEN THE CLUES DON'T POINT ANYWHERE

Some symptoms raise the **total** risk of cancer without naming the organ. Here you assess for clues, then choose between urgent investigation, a suspected cancer pathway referral, or the **non-specific symptoms pathway**.

Unexplained weight loss — aged 60+

NEW 2026

ACT For people aged **60+** with **unexplained weight loss >5% over 6 months**: **assess for additional features** that point to a site, then offer **urgent investigation**, a **suspected cancer pathway referral**, or a **non-specific symptoms pathway referral**.

THINK colorectal · gastro-oesophageal · lung · prostate · pancreatic · urological.

Unexplained appetite loss

ACT Assess for clues, then offer **urgent investigation**, a **cancer pathway** or a **non-specific symptoms pathway** referral.

Deep vein thrombosis

CONSIDER DVT links to urogenital, breast, colorectal and lung cancer. Assess for clues; **consider** investigation or referral.

▲ WHAT CHANGED

The **60+ unexplained weight loss** rule is new for 2026, and it now explicitly offers the **non-specific symptoms pathway** as a route — built for exactly these "something's wrong but I can't localise it" presentations. *NICE NG12, 2026*

♥ Safety netting & supporting the patient

Before they leave the room

- Explain they are going to a **cancer service**, and **reassure** that most people referred will not have cancer.
- Discuss **possible alternative diagnoses**, in line with how much they want to know.
- Assess what **support** they need while waiting; with consent, tell the specialist.
- Give information that is **culturally and linguistically appropriate**, pitched to their literacy.

Safety netting — two jobs

- **Timely review** and action once investigations come back.
- **Active monitoring** of people at low-but-not-no risk, watching for a change in their risk.
- Tell anyone **below the referral threshold** to come back if symptoms **persist or progress**.
- If a direct-access test isn't available locally, **find an alternative urgent pathway** — don't let access gaps stall the diagnosis.

◎ THE THREAD THAT TIES IT ALL TOGETHER

Referral criteria are a **floor, not a ceiling**. They tell you when you **must** act — they never tell you to stop worrying. A patient who doesn't meet a threshold but doesn't sit right with you gets a **plan and a safety net**, not a discharge.

▸ PRIMARY SOURCE

Every recommendation in this teaching aid is drawn from **NICE NG12 — Suspected cancer: recognition and referral**, published 23 June 2015 and **last updated 15 April 2026**, verified directly against nice.org.uk/guidance/ng12 in June 2026.

Key references

- **NICE NG12** — Suspected cancer: recognition and referral (updated Apr 2026).
- **NICE HTG690 / DG56** — quantitative FIT to guide colorectal referral.
- **British Menopause Society** — Management of unscheduled bleeding on HRT.
- **NICE CSG8** — improving outcomes for people with skin tumours including melanoma.
- **NICE NG127** — suspected neurological conditions (squint / red reflex).

Reading the pills & labels

48 HOURS very urgent — usually children & young people

2-WEEK PATHWAY suspected cancer pathway referral (28-day FDS)

DIRECT ACCESS a test you order and act on, within 2 weeks

ROUTINE non-urgent referral

REFER / OFFER = strong NICE recommendation. **CONSIDER** = clinical judgement applies.

◆ HOW TO GET THE MOST FROM THIS AID

Use it as a **fast lookup at the point of decision**, not a textbook. Learn the **referral language** on page 1 and the **seven changes** on page 2 first — they unlock everything else. For prescribing or any borderline case, go back to the **live NICE source** and your **local pathway**.

Disclaimer

This document is provided **exclusively for educational and training purposes** as a teaching aid. It does **not** constitute formal clinical guidance. Clinicians must **independently verify** all medical information, prescribing guidance, referral criteria, procedural protocols and legal requirements against **current national guidance (NICE NG12), local policies, and the relevant regulatory bodies** before applying anything in practice. Guidance changes; always confirm against the live source for your area before acting. Bradford VTS accepts no liability for any loss arising from reliance on this material.

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